U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 23 January 2007*In the Matter of*

E. C.
Claimant
v.

PEABODY COAL COMPANY,
Employer

Case No. 2005-BLA-05145

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:[1]
Brent Younts, Esquire
Claimant
Philip J. Reverman, Esquire
For the Employer

BEFORE: DANIEL F. SOLOMON
Administrative Law Judge

DECISION AND ORDER
AWARD OF BENEFITS

This proceeding arises from a request for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing requested by the Employer April 27, 2004. Director's Exhibit ("DX") 26.

Claimant was last employed in coal mine work in the state of Kentucky, the law of the United States Court of Appeals for the Sixth Circuit controls. See ***Shupe v. Director, OWCP***, 12 BLR 1-200, 1-202 (1989)(en banc). Since Claimant filed this application for benefits after January 1, 1982, Part 718 applies.

In June 1992, Claimant filed his first Application for Federal Black Lung benefits (DX 1-131). Following the development of evidence by the Department of Labor and the Parties, the Department issued a Decision and Order on July 6, 1993 denying benefits based on Findings that Claimant did not have pneumoconiosis and was not totally disabled by such a disease (DX 1-10).

[1] The Director, Office of Workers' Compensation Programs, was not present nor represented by counsel at the hearing.

Claimant filed his second Application for Federal Black Lung benefits on December 24, 2003 (DX 3-1). Following the development of evidence by the Department of Labor, the Department issued a Proposed Decision and Order on August 3, 2004 finding Claimant is entitled to benefits (DX 20-4). The Employer requested a Hearing on April 27, 2004 (DX 26-6), and the claim was referred to the Office of Administrative Law Judges on October 25, 2004 (Director Exhibit #26-1). A hearing was held on September 27, 2006 in Owensboro, Kentucky.

28 Director's Exhibits (DX 1-DX 28) were admitted into the record for identification. See transcript, "TR" 5. Four Claimant's Exhibits ("CX" 1- CX 4, TR 10) and three Employer's exhibits ("EX" 1 – EX 3, TR 49) were also admitted. Post hearing, Employer submitted a statement from Dr. Lawrence Repsher on October 11, 2006. No objection was received and it is admitted as EX 4.

Briefs were submitted by both the Claimant and Employer.

The Claimant is a 60 year-old high school graduate who has spent approximately 19 years of work in the coal mining industry for Peabody Coal Company (TR 9). He testified that he was a retired miner, TR-8; was 68 years of age, being born on February 17, 1938, TR-9; was married for 49 years, TR-9. He was a high school graduate, TR-9, and worked for Peabody Coal Company between 18-20 years, to 1988 or 1989 when the mine was shut down and he was laid off (TR 9, TR 27-28). During the last year that he worked for Peabody Coal Company, Claimant did not miss any extended periods of time from work because of illness or injury and was doing his job to the complete satisfaction of Peabody Coal Company right up until the time of the layoff (TR 28).

His jobs including running a bull dozer when he first started for Peabody, for 9-10 months, TR-9-10. He was doing reclamation work, TR-10. He testified that he operated the dozer in an open cab and was exposed to coal dust while operating the dozer and that there was no protection for breathing, TR-10.

His next job at Peabody was at the preparation plant, TR-10-11. At this plant he worked washing the coal and crushing it into fine dust and he did this as a laborer and then as an oiler. As such he swept dust and blew dust with a blower. Visibility was about zero due to the dust. There was no protective device at this location either, TR-12. He worked at this location for 7-8 years.

The Claimant's job as an oiler was "just a title" and he drew oiler's pay but all that he did was to put a little oil on a chain. His title changed and so did his income, but not his job.

His next job was to load coal in the pit and this was done on the shuttle, which had doors on it that could be closed but he was on the ground part of the time, also, TR-13-14. He alleges that about as much dust got inside as it stayed out and that it was blown out with an air hose. He also was covered by coal dust at this job, TR-14. He does not recall how long that he worked at this job but he worked there apparently until he last worked at Peabody, TR-15. He also indicated that he hauled coal in a 100-ton yuke off-road truck for approximately 2-3 years, which was also a dusty place as described by him at TR-15.

At the end of a typical day he was black and dirty all over; and he usually went home in that condition and took a shower when he went home and was unable to wear the same clothes the next day. TR 16. He was so dirty that, as he stated, one could see his eyeballs and teeth and that he even had dust underneath of his helmet, also.

When he left work in 1988 he states that he was having difficulty breathing. He could not do much but was able to more than what he can currently do. He had coughing and

production from the cough and that it was possibly a teaspoon full or two or three at a time when he had production (early in the morning, in the middle of the day and at dark), TR-17. He coughed "pretty constantly." TR 18.

In comparison of current symptoms with those at the time of leaving the mines he states, "I still cough up a lot more stuff than what I did." Also, that he coughs more often. On the day of the hearing he coughed up about a teacup that morning; it is clear and striped and that color and consistency are the same as when he left work, but there is more of it now. TR-18. Over the last 2-3 years it has gotten worse. He has been using oxygen for a little over 3 years, 24 hours per day, 7 days per week. The quantity of oxygen has increased from 1 liter up to 2 ½ liters, TR-19. In describing what this represents insofar as use of oxygen, he states that his breathing capacity "got worse." TR 20.

Claimant tried smoking as a teenager but did not start smoking until approximately 25 years ago and intermittently, did not smoke at all. Later, he might take a cigarette with a cup of coffee in the morning.

Following the layoff, Claimant became self-employed as a truck driver hauling logs (TR 28-29). He was able to perform this job to the time that he had a heart attack in 1991 or 1992 and has not held any type of gainful employment since he had the heart attack (TR 29). He applied for Social Security disability benefits based on his heart attack and drew those benefits until he became age 65 and began to draw regular Social Security retirement benefits (TR 29-30). In addition to his Social Security retirement benefits, Claimant draws a miner's pension of $200.00/month and has some farm income (TR 30).

The Claimant's wife confirmed that she and the Claimant had been married for 49 years, TR-38. She confirmed that when Claimant returned from work at Peabody Coal Company, that he was "always black, dirty." "Did not come into the house until he was washed up" and "it was just coal dust all over him," and that included his face and even under his helmet, TR-38.

Claimant's breathing got worse approximately 6-7 years ago; he breathed better when he left Peabody than he does now, but he coughed night and day and is more frequent now. He coughs 5, 6 or 7 times per day. She does not know the quantity but based upon her observations it is more frequent TR-40. She also described that he sleeps in a chair, sitting up on the bed, using a hospital bed, etc. due to shortness of breath, TR-41. He uses elevated pillows, chairs and hospital beds. The hospital bed has helped his sleeping patterns. She still hears him coughing at night, although he sleeps better with the elevated bed. She testified that that he never smoked around her.

Claimant can get from the bed to the couch now and that he can go to the bathroom, which is a very short distance, estimated by her to be about 25 feet, TR-45-46. Sometimes he cannot even do that. She has to help him with a variety of things, including putting on clothing and bathing, TR-46. He must rest ten minutes after a shower. He tries to do chores but he does not do "anything" now, however he used to mow the yard, go hunting and fishing and drive a car.

APPLICABLE STANDARDS

Because the Claimant filed this application for benefits after March 31, 1980, the regulations set forth at part 718 apply. ***Saginaw Mining Co. v. Ferda***, 879 F.2d 198, 204, 12 B.L.R. 2-376 (6th Cir. 1989).

This case represents an initial claim for benefits. To receive black lung disability benefits under the Act, a miner must prove that (1) he suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) he is totally disabled, and (4) his total disability is caused by pneumoconiosis. ***Gee v. W.G. Moore and Sons***, 9 B.L.R. 1-4 (1986) (en banc); ***Baumgartner v. Director***, OWCP, 9 B.L.R. 1-65 (1986) (en banc). ***See Mullins Coal Co., Inc. of Virginia v. Director***, OWCP, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987). The failure to prove any requisite element precludes a finding of entitlement. ***Anderson v. Valley Camp of Utah, Inc.***, 12 B.L.R. 1-111 (1989); ***Perry v. Director***, OWCP, 9 B.L.R. 1-1 (1986) 1-1 (1986) (en banc).

STIPULATIONS AND WITHDRAWAL OF ISSUES

1. The Claimant is a "miner" as that term is defined by the Act, and has worked after 1969. TR 51.

3. The Employer agreed that the Claimant had 19 years of coal mine employment. TR 51.

4. Peabody Coal Company is the responsible operator. DX 26.

5. The Claimant has one dependent. DX 26.

6. The Claimant is totally disabled from a respiratory impairment. TR 51.

7. Since the Claimant has established total disability, one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 CFR § 725.309(d). TR 52.

After a review of the stipulations and the record, they are accepted.

REMAINING ISSUES

1. Whether the miner suffers from pneumoconiois.
2. If so, whether the miner's pneumoconiosis arose out of coal mine employment.
3. Whether the miner's total disability is due to pneumoconiosis.

BURDEN OF PROOF

"Burden of proof," as used in this setting and under the Administrative Procedure Act[2] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[3] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of labor v. Greenwich Collieries [Ondecko]***, 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[4]

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[2] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, ant hearing held under this chapter shall be conducted in accordance with [the APA]; 5 U.S.C. § 554(c)(2). Longshore and Harbors Workers' Compensation Act ("LHWCA") 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[3] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director***, OWCP [Sainz], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[4] Also known as the risk of non-persuasion, *see* 9 J. Wigmore, Evidence § 2486 (J. Chadbourn rev. 1981).

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production; the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

TIMELINESS

Timeliness is a jurisdictional matter that can not be waived. 30 U.S.C. § 932(f), provides that "[a]ny claim for benefits by a miner under this section shall be filed within three years after whichever of the following occurs later": (1) a medical determination of total disability due to pneumoconiosis; or (2) March 1, 1978. The Secretary of Labor's implementing regulations at 20 C.F.R. § 725.308 sets forth in part, as follows:

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later. There is no time limit on the filing of a claim by the survivor of a miner.

(c) There shall be a rebuttable presumption that every claim for benefits is timely filed. However, except as provided in paragraph (b) of this section, the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

Employer argues that under applicable case law and the Claimant's own testimony, it is "clear" the current Application has not been timely filed and must be dismissed. I am advised that since the current claim was filed on December 24, 2003, Claimant's claim would not be timely filed if he was advised of a medical determination of total disability due to pneumoconiosis prior to December, 2000. Claimant filed his first Application for Federal benefits on June 9, 1992 (DX 1-131). I am reminded that in addition to filing a claim for Federal benefits at that time, Claimant also filed a claim for State Black Lung benefits with the State of Kentucky (TR 31). Claimant testified that when he filed those claims in the 1990's, he had been told by a physician that he had contracted "pneumoconiosis or black lung", and that he was additionally told by a physician at that time that he was totally disabled by "black lung" (TR 31-32).

I am directed to ***Tennessee Consolidated Coal Company v. Kirk***, 264 F. 3d 602 (2001). In that case, the Sixth Circuit held that the three year limitations clock for a filing of a claim by a miner begins to start when the miner is told by a physician that he is totally disabled by pneumoconiosis, and that it may only be turned back if the miner returns to work in the mines. Besides the regulatory presumption that every claim is timely filed the regulation also provides that the time limits maybe waived or tolled upon a showing of exceptional circumstances. The regulation requires a written medical report, probative, reasoned and documented, indicating total respiratory disability due to pneumoconiosis. The Board also held that this report must be communicated to the miner in writing: "oral statements to the miner. . . are insufficient." ***Adkins v. Donaldson Mine Company***, 19 BLR 1-36, at 1-43 (1993).

The party opposing entitlement bears the burden of rebutting the presumption of timeliness, and even if rebuttal is established, the Administrative Law Judge must the determine

whether "extraordinary circumstances" exist, thus tolling the time limit. See also ***Daugherty v. Johns Creek Elkhorn Coal Corp.***. 19 BLR 1-95 (1994).

Although the Employer proved that a report of total disability due to pneumoconiosis was communicated, TR 31-32, the predicate is the production of a well reasoned report. The Claimant also testified that he was not compensated for total disability due to pneumoconiosis at the state level. TR 36. The Employer's brief does not direct me to such a report. I asked about it on the record, TR 50, and Employer has not proffered anything to me.

Employer did elicit that the Claimant's physician was William O'Brien. But the Claimant did not identify Dr. O'Brien's diagnosis. "He called it something. I don't know what he called it." TR 32. This does not constitute adequate communication.

I have reviewed all of the evidence in the record and the proffered evidence does not rebut the presumption.

MEDICAL EVIDENCE SUMMARY

Current X-rays

Exhibit No.	Physician	BCR/BR	Date of film	Reading
CX 2	Baker	B	1/23/04	1,0
DX 19	Wiot	B, BCR	1/23/04	Negative
CX 2	Baker	B	9/11/04	1,1
CX 1	Whitehead	B	"	1,0
EX 2	Spitz	B, BCR	"	Negative
DX 11	Simpao		12/3/04	1,0[5]
EX 1	Repsher	B	7/12/05	Negative

Prior to the hearing, Claimant had originally referenced an August 13, 1992 chest x-ray taken by Dr. Sam Traughber, in the prior file (DX 1). Dr. E. N. Sargent, a Board-Certified Radiologist and "B" Reader, read the same x-ray as negative. Id.

Pulmonary function studies

Exhibit No.	Physician	Date of study	Tracings present?	Flow-volume loop?	Broncho-dilator?	FEV1	FVC/ MVV	Coop. and Comp. Noted?
DX 11	Simpao	1/23/04	Yes	Yes	No	.056	1.25	Good
EX 1	Repsher	7/12/04	Yes	Yes	No	.094	2.32	Good
CX 2	Baker	9/11/04	Yes	Yes	No	.097	2.44	Fair
EX 3	Fino	Commented that DX 11 is invalid due to lack of reproductibility.						

Blood gas studies

[5] This x-ray was read for quality purposes only by Peter Barnett, M.D. a board certified B reader radiologist. DX 12.

Exhibit No.	Physician	Date of Study	Altitude	Resting (R) Exercise (E)	PCO2	PO2	Comments
DX 11	Simpao	1/23/04	0-2999	R	40.7	78.8	Borderline
CX 1	Baker	9/11/04	"	R	44	64	
EX 1	Repsher	7/12/04	"	R	45.7	58	

Medical Reports

Valentino Simpao, M.D.

Dr. Simpao, a Family Practitioner, conducted an examination of the Claimant on January 23, 2004 at the request of the Department of Labor. Dr. Simpao found both clinical and legal pneumoconiosis. DX 11. This was based upon reading an x-ray in part, but was also based on nineteen (19) years of exposure to coal dust, and the results of pulmonary function studies, which produced values well below the disability standards. Dr. Simpao found that the Claimant had "severe restrictive and severe obstructive airway disease." Further, he noted that the coal dust exposure for the nineteen years was medically significant to his pulmonary impairment. DX 11. Dr. Simpao was also deposed. CX 3.

Glen Baker, M.D.

Dr. Baker examined the Claimant on September 11, 2004. CX 2. He also diagnosed both clinical and legal pneumoconiosis. A history of wheezing, chronic bronchitis, heart problems and treatment for pneumonia are noted. The Claimant alleged sputum production of approximately 1 ½ teaspoon every 24 hours for 8 - 10 years on a daily basis; wheezing for 8-10 years on a daily basis; dyspnea for 8-10 years with the ability to walk 30-40 feet on level ground; coughing on a daily basis for 8-10 years; chest pain for 13-14 years associated with a myocardial infarction, and ankle edema occasionally. Prescribed oxygen of 2 liters, a nebulizer and Advair are noted.

Dr. Baker, a B-reader, read an x-ray as 1/1. A severe obstructive ventilatory defect, FEV1 of 40% and an FEV1/FVC ratio of 40, are reported. The arterial blood gas studies yielded moderate resting arterial hypoxemia. A decreased PO2 is seen as stemming by significantl contribution from coal dust exposure.

Dr. Baker opined that Claimant has a Class III impairment of between 40 and 59% of predicted and would be unable to do the work that he has done in the past as a coal miner or do comparable work in a dust-free environment. Dr. Baker determined that chronic obstructive airway disease, resting arterial hypoxemia and chronic bronchitis have been significantly related to and significantly aggravated by coal dust exposure in the coal mining industry. Id.

Lawrence Repsher, M.D.

Dr. Repsher, a Pulmonary Specialist and "B" Reader, had examined the Claimant on July 12, 2004 (EX 1). Although he found that testing establishes that the Claimant is totally disabled from a severe obstructive ventilatory impairment, Dr. Repsher reported that the Claimant showed (1) no radiographic evidence of pneumoconiosis in that both a chest x-ray and a CT-scan showed no evidence of the disease; (2) no pulmonary function testing evidence of pneumoconiosis since the pulmonary function test yielded findings consistent with bullous emphysema caused by

cigarette smoking; (3) no arterial blood gas evidence of pneumoconiosis (EX 2). Dr. Repsher stated that the high resolution CT-scan done of Claimant's chest involved a test which was medically acceptable for the evaluation of pulmonary diseases, and a test which is beneficial in confirming or denying the presence of pneumoconiosis when it is not evident on routine chest x-rays (EX 4). He found the following:

1. No evidence of coal workers pneumoconiosis .
2. No evidence of any other pulmonary or respiratory disease or condition, either caused by or aggravated by his employment as a coal miner with exposure to coal mine dust.
3. COPD [chronic obstructive pulmonary disease] and bullous emphysema, severe, secondary to chronic cigarette smoking.
4. Recent history of pneumonia with post inflammatory chest x-ray changes and early bronchiectasis, left lower lobe.
5. Diabetes mellitus.
6. Coronary artery disease, manifested by acute myocardial infarction in 1991.
7. History of right CVA.
8. Status post AAA repair and left carotid endarterectomy.
9. Peripheral vascular disease with bilateral intermittent claudication in the lower extremities.
10. History of congestive heart failure.

EX 1.

Gregory Fino, M.D.

Dr. Fino, a Pulmonary Specialist and "B" Reader, reviewed all of the medical records and/or reports contained in all of the Applications filed by the Claimant (EX 3). Based upon his review of these records, although the Claimant is totally disabled from a respiratory impairment, it was Dr. Fino's opinion that there was insufficient medical evidence to justify a diagnosis of coal worker's pneumoconiosis. Disability is entirely due to cigarette smoking. Id.

"Other" Medical Evidence

Exhibit No.	Physician	Date of Medical Report	Type of Procedure	Comments
EX 1, EX 4	Repsher	8/5/04	CT	No pneumoconiosis.

FINDINGS OF FACT

TOTAL DISABILITY

To receive black lung disability benefits under the Act, a claimant must establish total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary

condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

The Employer stipulated that total disability exists in this record.

The record does not contain sufficient evidence that Claimant has complicated pneumoconiosis and there is no evidence of cor pulmonale with right sided congestive heart failure. As a result, the Claimant must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

All of the recent medical reports accept and the record shows that Claimant has established total respiratory disability.

Therefore, I find that the Claimant has established one of the criteria under 20 CFR § 725.309, total disability.

Existence of Pneumoconiosis

Pneumoconiosis is defined as a chronic dust disease arising out of coal mine employment.[6] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as any chronic lung disease. . .arising out of coal mine employment.[7] The regulation further indicates that a lung disease arising out of coal mine employment includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b). As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. ***Kline v. Director, OWCP***, 877 F.2d 1175 (3d Cir. 1989).

A living miner can demonstrate the presence of pneumoconiosis by: (1) chest x-rays interpreted as positive for the disease (§ 718.202(a)(1)); or (2) biopsy report (§ 718.202(a)(2)); or the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or (4) a reasoned medical opinion which concluded the disease is present, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function tests, physical examinations, and medical and work histories. (§ 718.202(a)(4)).

X-ray Evidence

The record I consider under the rules for limitations on evidence involves seven readings of four x-rays in the current record. The prior record includes x-rays, but they are more than ten years old and as they are conflicted, I find they are not as helpful as the newer evidence. Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. ***Clark v. Karst-;Robbins Coal Co***., 12 B.L.R. 1-;149 (1989)(en banc); ***Casella v. Kaiser Steel Corp***., 9 B.L.R. 1-;131 (1986). The Claimant relies on readings by a B readers, Dr. Baker and Dr. Whitehead. Another positive reading is by Dr. Simpao, who is not a B reader. Drs. Wiot and Spits are dually qualified board certified radiologist B readers. Dr. Repsher is a B reader. Of the most recent readings, the positive readings outweigh the negative four to three.

The weight I must attribute to the x-rays submitted for evaluation with the current application are in dispute. "[W]here two or more X-ray reports are in conflict…consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."

[6] 20 C.F.R § 718.201(a).

[7] 20 C.F.R. § 718.201(a)(1) and (2) (emphasis added).

718.202(a)(1). I am "not required to defer to…radiological experience or…status as a professor of radiology." ***Dempsey v. Sewell Coal Co***., 23 BLR 1-47 (2004).

I note that of the readers of record, Dr. Wiot and Dr. Spitz are the best qualified.

I note that the preponderance of the readers do find pneumoconiosis.

The Board has held that I am not required to defer to the numerical superiority of x-ray evidence, ***Wilt v. Wolverine Mining Co***., 14 B.L.R. 1-70 (1990), although it is within his or her discretion to do so, ***Edmiston v. F & R Coal Co***., 14 B.L.R. 1-65 (1990). See also ***Schetroma v. Director, OWCP***, 18 B.L.R. 1- (1993) (use of numerical superiority upheld in weighing blood gas studies); ***Tokaricik v. Consolidation Coal Co***., 6 B.L.R. 1-666 (1984) (the judge properly assigned greater weight to the positive x-ray evidence of record, notwithstanding the fact that the majority of x-ray interpretations in the record, including all of the B-reader reports, were negative for existence of the disease). See also ***Woodward v. Director, OWCP***, 991 F.2d 314 (6th Cir. 1993).

In this case, the expert opinions of the most qualified reader dictate a conclusion that is opposite to the numerical number of opinions. The evidence from the prior record is inconclusive. The Claimant has a burden to prove the existence of pneumoconiosis by a preponderance of the evidence. ***Director, OWCP, Department of labor v. Greenwich Collieries [Ondecko],*** *supra.* I find that pneumoconiosis has not been established by x-ray.

Biopsy and Presumption

Claimant has not established pneumoconiosis by the provisions of subsection 718.202(a)(2) since no biopsy evidence has been submitted into evidence. The presumptions to not apply.

Medical Reports

20 C.F.R. § 718.202(a)(4) sets forth:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in Section 718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

"Legal pneumoconiosis is a much broader category of disease" than medical pneumoconiosis, which is "a particular disease of the lung generally characterized by certain opacities appearing on a chest x-ray." ***Island Creek Coal Co. v. Compton***, 211 F.3d 203 at 210 (4th Cir. 2000). The burden is on the Claimant to prove that his coal-mine employment caused his lung disease. 20 C.F.R. § 718.201(a)(2). A disease "arising out of coal mine employment" is one that is significantly related to, or substantially aggravated by, coal dust exposure. 20 C.F.R. § 718.201(b). ***Cornett v. Benham Coal, Inc***., 227 F.3d 569, 576 (6th Cir. 2000).

Dr. Simpao is the Director of the Coal Miner's Clinic at the Muhlenberg Community Hospital and has been the Director since the early 1970's. He diagnosed both clinical and legal coal workers' pneumoconiosis based upon his reasoned opinion and his diagnosis of pneumoconiosis is based upon pulmonary function tests, physical findings, spirometry, use of inhaler and the number of years in his occupational history, clinical findings and symptomotology of the Claimant. The face, lips and nails are plethoric or cyanotic, which Dr.

Simpao finds is related to the distribution of oxygen in the peripheral appearance of the Claimant. CX 2, 9-10. He noted the smoking history. Although he noted that the influence of smoking and coal dust could not be determined as to the degree of influence, pneumoconiosis was attributed as the primary cause of the Claimant's lung condition.

In his deposition, Dr.Simpao testified that it is not possible to separate the smoking history with the history of coal dust exposure to render a differential diagnosis. Id. at 17.

On cross examination, Dr. Simpao indicated that he did take into account this reading of the x-ray, at 22, and admitted that a smoking history like Claimant's can cause emphysema and bronchitis, and an obstructive impairment. Id. at 24, 25. Likewise, the cyanotic findings can stem from smoking. Id. at 26. But he denied that the dysfunction is the sole result of cigarette smoking. Id. at 27.

Dr. Baker's opinion is similar to Dr. Simpao's.

Both Dr. Repsher, who examined the Claimant, and Dr. Fino, who did not, acknowledge that the Claimant is disabled, but they aver that it is not from pneumoconiosis. Dr. Repsher uses the following to rule out a diagnosis of pneumoconiosis:

1. He has no chest x-ray or chest CT scan evidence of coal workers pneumoconiosis.
2. He has no pulmonary function test evidence of coal workers pneumoconiosis. His pulmonary function tests are consistent with severe bullous emphysema, due to his long and substantial cigarette smoking history.
3. He has no arterial blood gas evidence of coal workers pneumoconiosis.
4. He is suffering from a number of other serious and potentially serious medical problems. However, none of these conditions can be fairly attributed to his work as a coal miner with exposure to coal mine dust. Rather, they are disease of the general population, primarily related to heredity and lifestyle factors.

EX 1.

I agree that there is no evidence of clinical pneumoconiosis in this record. The CT scans are diagnostic of clinical but not legal pneumoconiosis. In reading Dr. Repsher's report, one must assume that there is a method in reading the spirometry to differentiate bullous emphysema from pneumoconiosis. The testing is reported as follows:

> Pulmonary function tests reveal a severe obstructive ventilatory impairment. Lung volumes demonstrate hyperinflation with air trapping. The diffusion capacity is reduced to a moderately severe degree. Arterial blood gases demonstrate moderately severe arterial hypoxemia with mild CO2 retention and an over compensated respiratory acidosis, due to underlying metabolic alkalosis. The carboxyhemoglobin level is normal. Serum nicotine and cotinine levels are elevated. Resting electrocardiogram demonstrates multiple premature ventricular complexes~ left axis deviation, and nonspecific T wave abnormalities. The CBC and sed rate are normal. Comprehensive metabolic panel demonstrates a mild elevation in BUN with an upper limits of normal serum creatinine. Blood glucose is significantly elevated to 322 and the alkaline phosphatase is mildly elevated at 132.

EX 1.

Dr. Repsher does not explain how those findings differentiate smoking from pneumoconiosis. I note that carboxyhemoglobin is often used to show smoking, but no explanation is given. I also note that according to Dr. Simpao, there is also a restrictive component to the Claimant's impairment.

During the course of Dr. Simpao's deposition, he was asked to comment on all of the bases that Dr. Repsher used to "rule out" a diagnosis of pneumoconiosis. Although he acknowledged that it is possible to induce the same symptoms from cigarette smoking, he addressed each of those factors to show that it is equally plausible to accept pneumoconiosis as a diagnosis. He addressed both clinical and legal pneumoconiosis. I find his explanation is more plausible than Dr. Repsher's explanation.

Dr. Fino submitted his summary of learned articles on the subject. None show that there is any way to differentiate pneumoconiosis from cigarette smoking in the manner of testing that has been performed on this Claimant. Moreover, at page 10 of his report, his explanation pertains solely to clinical pneumoconiosis, and the logic offered is inappropriate to legal pneumoconiosis. I also note that the explanation is confusing and self contradicting. He does not show how the "negative relationship" pertains between the emphysema score and the FEV1 percentage rates relates to this record.

I note that Drs. Baker, Repsher and Fino are pulmonary specialists while Dr. Simpao is not board certified in pulmonology.

The Employer reminds me that Claimant's physicians did not apportion the impairment to determine which part was due to cigarette smoking and how much to coal dust exposure. However, the Benefits Review Board in applying the Act has ruled that as long as a totally disabling impairment was due to both cigarette smoking and coal dust exposure, that opinion establishes that part of the Claimant's impairment was due to cigarette smoking. See ***Crusenberry v. ABM Coal Company***, BRB No 06-271 (Unpublished, November 24, 2006), citing to ***Cornett***, *supra*, that the impairment was at least in part due to pneumoconiosis. In Crusenberry, the Board evaluated an opinion of Dr. Baker that is exactly like the opinion rendered in this record.

After a review of all of the evidence, I attribute less weight to the opinions of Dr. Fino than to those of Dr. Simpao and Baker. He did not examine the Claimant and much of his reasoning derives from Dr. Repsher's findings. ***Cole v. East Kentucky Collieries***, 20 B.L.R. 1-51 (1996) (the administrative law judge acted within his discretion in according less weight to the opinions of the non-examining physicians; he gave their opinions less weight, but did not completely discredit them). I have already addresses what I consider to be faulty logic in an attempt to undermine Dr. Simpao's testimony that there is no way to differentiate between the effects of cigarette smoking and pneumoconiosis.

Although Dr. Simpao is not board certified and Dr. Repsher is, as the director of a Black Lung clinic, I find that he is qualified to diagnose black lung disease. Symptoms include wheezing, shortness of breath and coughing and tightness as well as ankle edema. I find that Dr. Baker is equally qualified as Dr. Repsher. Dr. Baker explains his diagnosis of legal pneumoconiosis on a moderate to severe obstructive ventilatory defect, a moderate decrease in resting P02 and mild chronic bronchitis. "This can be both to his cigarette smoking as well as coal dust exposure. He has about 25-pack year history of smoking and 20-year history of coal dust exposure. Therefore, his chronic obstructive airway disease, resting arterial hypoxemia and chronic bronchitis have been significantly related to and significantly aggravated by coal dust exposure in the coal mining industry."

After a review of the evidence, I find that Dr. Repsher did not significantly explain why reliance on testing might be valid to rule out a diagniosis of pneumoconiosis. Moreover, the effect of a combination of factors is left unexplained. Dr. Baker addresses the effect of an aggravation by coal dust, so that even if the miner had emphysema due to cigarette smoking, the

secondary effect of exposure to coal dust is likely. In fact, Dr. Simpao was asked about the chronic obstructive pulmonary disease. CX 2 at 24. He noted that there was also a restrictive component. Id, 26, 33-34.

I find that Dr. Simpao and Dr. Baker submitted reports and testimony that constitute a "reasoned medical opinion" that establishes that legal pneumoconiosis in more than a de minimus factor in the Claimant's respiratory impairment. ***Grundy Mining Co. v. Director, OWCP [Flynn]***, 353 F.3d 467 (6th Cir. 2003).

CAUSATION

A miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 CFR 718.203(b). I have discounted the opinions of Drs Repsher and Fino, who do not accept a diagnosis of pneumoconiosis, which is contrary to the full weight of the evidence. ***Howard v. Martin County Coal Corp.***, 89 Fed.Appx. 487 (6th Cir., 2003, unpbl.). ["ALJ could only give weight to those opinions if he provided specific and persuasive reasons for doing so, and those opinions could carry little weight, at the most." ***Scott v. Mason Coal Co***., 289 F.3d 263 (4th Cir. 2002)]. ***Tapley v. Bethenergy Mines, Inc***., BRB No. 04-0790 BLA (May 26, 2005) (unpub.). The record establishes 19 years of coal mine employment. I credit the opinions of Dr. Simpao and Baker on this point. Therefore, I find that the miner's pneumoconiosis arose at least in part out of coal mine employment.

TOTAL DISABILITY DUE TO PNEUMOCONIOSIS

Claimant needs to establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 C.F.R. §718.204(c)(1). The Benefits Review Board has held that §718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. ***Baumgardner v. Director, OWCP***, 11 B.L.R. 1-135 (1986).

I credit Drs. Simpao's and Baker's reports and Dr. Simpao's deposition testimony that establishes causation. Again, I discount Drs. Repsher's and Fino's opinions as poorly reasoned, as their opinions are contrary to my finding on pneumoconiosis. ***Cornett v. Benham Coal, Inc.***, 227 F.3d 569, 576 (6th Cir. 2000). I also reject their position that no respiratory deficit exists in this record.

Dr. Simpao and Dr. Baker both note that smoking and pneumoconiosis significantly contributed to total disability. I accept the Claimant's testimony that his work required heavy lifting and requires significant stooping and crawling. I accept Dr. Simpao's finding that the Claimant has both severe restrictive and severe obstructive airway disease which are legal pneumoconiosis and which preclude past relevant work. Based on reasons more fully set forth above in the discussion of pneumoconiosis and total disability, I accept this premise.

Therefore, I find that pneumoconiosis was a substantial contributing cause to the miner's disability. 20 C.F.R. §718.204(c)(1).

ENTITLEMENT

I find that Claimant has established entitlement to benefits. Pursuant to 20 CFR §725.503, benefits are payable as of the month of onset of total disability and if the evidence does not establish the month of onset, benefits are payable beginning with the month during which the claim was filed.

The Claimant was evaluated by Dr. Simpao in January, 2004. DX 11. I accept the determination that the Claimant was totally disabled due to pneumoconiosis at that time, and it is reasonable to expect that he had the same symptoms when he applied on December 24, 2003.

Therefore, I find that benefits are payable as of the month during which Claimant filed the claim, December, 2003.

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for the Claimant's counsel to submit an application. ***Bankes v. Director***, 8 BLR 2-l (l985). The application must conform to 20 C.F.R. 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including the Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

ORDER

The claim for benefits filed by **E.C.** is hereby **GRANTED**. Augmentation benefits for one dependent are also granted.

A

DANIEL F. SOLOMON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).